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Supreme Court of the United States

OCTOBER TERM, 1982

CITY OF AKRON,

Petitioner,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *ET AL.*,

Cross-Petitioners,

—v.—

CITY OF AKRON, *ET AL.*,

Cross-Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF OF AMICI CURIAE PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, INC., ASSOCIATION OF PLANNED PARENTHOOD PHYSICIANS, INC., SOCIETY FOR ADOLESCENT MEDICINE, THE AMERICAN JEWISH CONGRESS, THE CENTER FOR POPULATION OPTIONS, THE AMERICAN JEWISH COMMITTEE, THE AMERICAN PSYCHIATRIC ASSOCIATION, THE AMERICAN ASSOCIATION OF SEX EDUCATORS, COUNSELORS AND THERAPISTS, THE NATIONAL COUNCIL OF JEWISH WOMEN AND CERTAIN MEDICAL SCHOOL DEANS AND PROFESSORS IN SUPPORT OF RESPONDENTS AND CROSS-PETITIONERS

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INTEREST OF AMICI*

Planned Parenthood Federation of America, Inc. (PPFA) is a not-for-profit corporation organized in 1922 and existing under the laws of the State of New York. It is the leading national voluntary public health organization in the field of family planning. PPFA has 190 affiliates in forty-three states and the District of Columbia. These affiliates operate approximately 691 family planning clinics offering services to the public. Thirty-nine affiliates offer abortion services as part of their program. Most Planned Parenthood affiliates which do not perform abortions offer pregnancy counseling and referral.

The National Family Planning and Reproductive Health Association, Inc. (NFPRHA) is a national private non-profit membership organization, headquartered in Washington, D.C., devoted to the improvement and expansion of the delivery of family planning and reproductive health care services throughout the United States. With over 1300

*All parties have given their consent to the filing of this brief in letters filed with the Clerk of this Court.

members, it is the largest organization in the nation composed of providers and consumers of family planning and reproductive health care services.

The Association of Planned Parenthood Physicians, Inc. (APPP) is a New York not-for-profit corporation APPP has 670 members, all of whom are physicians or health professionals associated with family planning.

The Society for Adolescent Medicine is a national organization of health care providers to the adolescent age population. It consists of 900 active members all of whom are physicians and other health professionals.

The American Jewish Congress, a national organization of American Jews, was founded to protect the fundamental freedom of Jews and all Americans. It neither favors nor opposes abortion but believes that a woman's decision whether to undergo abortion must be her own, uncoerced by government.

The Center for Population Options (CPO) is a national organization concerned with the prevention of unintended adolescent pregnancy. CPO's projects are designed to assist adolescents in making informed choices about sex and parenthood. CPO believes that the adolescent's option as to whether or not to have an abortion must be maintained.

The American Jewish Committee (AJC) is a national organization which was founded in 1906 for the purpose of protecting the civil and religious rights of Jews. It believes that this goal can best be accomplished by helping to preserve the constitutional rights of all Americans. Specifically, the AJC supports access to abortion on a voluntary basis as an important component of comprehensive and effective health care and as part of our traditional concern for individual liberty, privacy and free choice.

The American Psychiatric Association is the nation's largest organization of physicians who specialize in the practice and study of psychiatry; approximately 27,000 of the nation's 34,000 psychiatrists are members. The Association has long had a policy

favoring medically appropriate abortions, because the opportunity to obtain such abortions implicates major psychiatric concerns.

The American Association of Sex Educators, Counselors and Therapists is a national non-profit membership organization. Its aims are to assist those professionals responsible for sex education, counseling and therapy programs by providing standards of competency in these areas.

The National Council of Jewish Women has 100,000 members. It has resolved to work to protect a woman's right to reproductive freedom.

Individual Professors, Physicians and Medical School Deans practice obstetrics and gynecology as their medical specialty or are responsible for the education of medical students and residents, some of whom are in training in the specialty of obstetrics and gynecology.

Amici submit this brief in order to demonstrate for the Court the impact of the Akron, Ohio Ordinance on the health and welfare of pregnant women.

SUMMARY OF ARGUMENT

Amici submit this brief in support of Cross-Petitioners/Respondents, Akron Center for Reproductive Health, et al.

Section 1870.06(B) of the Akron Ordinance, requiring that a physician recite to every patient a forty-four line script, including descriptions of fetal anatomy and false or unproven statements regarding abortion risks and consequences, violates a woman's right to rely upon the unimpeded advice of her physician in deciding whether or not to have an abortion. In so far as this section of the Ordinance compels speech affirming certain beliefs and opinions, physicians' first amendment rights are violated. In so far as patients are required to listen to these statements as a precondition to exercising their right to abortion, their first amendment right to refuse the state's ideological messages is violated.

Section 1870.06(C) of the Ordinance, requiring that the attending physician personally conduct informed consent counseling, impedes the physicians' exercise of best medical judgment by prohibiting the delegation of

the informing function to a trained paraprofessional.

Section 1870.07 of the Ordinance, requiring that a woman wait twenty-four hours between the time she consents to and receives an abortion, will result in lengthy delays, well beyond twenty-four hours, and increase health risks and financial costs. No state interest justifies such an inflexible requirement.

Section 1870.03 of the Ordinance, requiring performance of all post-first trimester abortions in hospitals, is not a reasonable means of protecting maternal health. The Court is here referred to amici's argument on this point in a brief filed in a related case. A new study demonstrates the difficulty in obtaining dilatation and evacuation abortions in hospitals.

Section 1870.05(B) of the Ordinance, requiring parental or judicial consent to minors abortions, impermissibly grants a veto power to third parties of even a mature minor's abortion choice.

I. SECTION 1870.06 (B) OF THE AKRON ORDINANCE UNDULY BURDENS A WOMAN'S RIGHT OF CHOICE REGARDING ABORTION AND ABRIDGES FIRST AMENDMENT RIGHTS OF PHYSICIANS AND PATIENTS

A. Section 1870.06 (B) Unduly Burdens A Woman's Right of Choice Regarding Abortion

Section 1870.06 (B) of the Akron Ordinance requires the physician to orally recite certain statements to every woman requesting an abortion, including inter alia:

> (3) That the unborn child is a human life from the moment of conception and (describe) in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external members.

and

> (5) That abortion is a major surgical procedure, which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may

have, and can result in severe emotional disturbances.

The Ordinance compels the physician, on pain of criminal penalty, to make these statements regardless of his or her judgment as to their veracity or their effect on the patient's well-being. Moreover, every woman, regardless of her emotional state or desire to receive the prescribed information, must listen to these statements as a pre-condition of obtaining a legal abortion. Because this section of the Ordinance places unjustified obstacles in the path of both the woman and the physician upon whom she is entitled to rely for advice in connection with her abortion decision, it must be held unconstitutional.

In affirming a woman's right to abortion, this Court has repeatedly linked that right to the physician's unimpeded ability to exercise responsible professional judgment in determining the need for and method of effectuation of the abortion. This is because the woman's exercise of her abortion right is encumbered "by placing

obstacles in the path of the doctor upon whom she (is) entitled to rely for advice in connection with her decision." Whalen v. Roe, 429 U.S. 589, 604 n. 33 (1977). Accordingly, the Court has repeatedly struck down laws which intrude on the physician's discretion in the abortion context. See e.g., Doe v. Bolton, 410 U.S. 179, 199 (1973) (striking down requirement of second doctor and committee concurrence in attending physician's judgment that an abortion is necessary); Colautti v. Franklin, 439 U.S. 377, 396-97 (1979) (striking down law which did not leave physician sufficient discretion to make his best medical judgment regarding fetal viability).

The Court has extended this principle to states' efforts to assure that women give informed and voluntary consent to abortion. In Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976), Missouri's requirement that a woman certify in writing that her consent to abortion was informed and freely given was upheld. The Court cautioned, however, that should

the term "informed consent" be interpreted to mean more than "the giving of information to the patient as to just what would be done and... as to its consequences," the statute "might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession." Id. at 67 n. 8.

Relying on Danforth's proviso, four federal courts of appeals, including the court below, and numerous federal district courts, have struck down laws similar to Akron's as constituting just such an unconstitutional "straitjacket" for the woman's physician. See e.g., Planned Parenthood League of Mass. v. Bellotti, 641 F.2d 1006 (1st Cir. 1981), Akron Center for Reproductive Health v. City of Akron, 651 F.2d 1198 (6th Cir. 1981), Charles v. Carey, 627 F.2d 772 (7th Cir. 1980), Planned Parenthood Association of Kansas City, Mo. v. Ashcroft, 655 F. 2d 848 (8th Cir. 1981), Margaret S. v. Edwards, 488 F.Supp. 181 (E.D.La. 1980), Planned Parenthood

of Rhode Island v. Roberts, 530 F.Supp. 1136 (D.R.I. 1982).

The Akron Ordinance goes far beyond a simple requirement of disclosing what is to be done and its consequences. Rather, it requires the physician to recite a forty-four line script regardless of his best medical judgment and his patient's wishes. This requirement is more than a mere annoyance. It requires the physician to speak and the patient to listen to a text containing information which may be emotionally distressing, if not physically harmful, and is in part empirically false and medically irrelevant. It is precisely the sort of "uncomfortable straitjacket" the Court envisioned in Danforth.

In establishing the parameters of what is permissible and impermissible in abortion consent laws, this Court should look to the standards already established by the law of medical malpractice for obtaining informed consent to all types of medical care. Physicians daily rely on these standards to determine what disclosures to make

to their patients. The Court in Danforth implied that this was the appropriate measure of the physician's duty. Its statement that informed consent means "what is to be done and its consequences" is an obvious reference to the tort law standard. Further, it is clear that the Court upheld the Missouri requirement because it required no greater disclosure than would be warranted for any other medical procedure. 428 U.S. at 67. This approach is in accord with this Court's long recognition that the judicial remedies generally afforded by the civil law for abuses of medical judgment afford adequate protection to the abortion patient. Roe v. Wade, 410 U.S. 113, 166 (1973). In fact, it is the very existence of these remedies that have precluded further state intervention in a woman's abortion decision during the first trimester. Id. See also, Connecticut v. Menillo, 423 U.S. 9, 11 (1975).

The physician's common law duty to inform a patient about the nature and risks of a proposed treatment

has arisen out of a recognition that "(e)very human being of adult years and sound mind has a right to determine what shall be done with his own body," and that "(t)rue consent to what happens to one's self is the informed exercise of a choice and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each." Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir. 1972), cert. denied, 409 U.S. 1064 (1972). Consequently, a physician who has not obtained informed consent from a patient may be liable for damages if an undisclosed risk eventuates in injury to the patient. Id. at 790.

The elements of informed consent at tort include disclosure of the nature of a proposed treatment, its risks and benefits and its

alternatives. Id. at 781-82[1/]. The adequacy of disclosure has traditionally been judged against community medical standards, but the modern view is to measure the physician's duty by the patient's needs.[2/] Every risk, no matter how small or remote, need not be revealed. The test for whether or not a particular peril should be revealed is its materiality to the patient's decision.

1/ See also, Ohio Rev. Code Ann. § 2317.54 (1981) Consent is valid and effective when the patient signs a written statement that sets forth "in general terms the nature and purpose of the procedure or procedures, and what the procedures are expected to accomplish, together with the reasonably known risks and, except in emergency situations, sets forth the names of the physicians who shall perform the intended surgical procedures." Thus, the City of Akron has singled out abortion for a higher standard of disclosure than is currently required by Ohio law generally. Such discrimination has been recently held to be grounds for striking down a similar "informed consent" law. Planned Parenthood of Rhode Island v. Roberts, 530 F.Supp. 1136, 1152 (D.R.I. 1982).

2/ A. Rosoff, Informed Consent: A Guide for Health Care Providers 38 (1981) (hereinafter cited as "Informed Consent")

> (T)he issue of nondisclosure must be approached from the viewpoint of the reasonableness of the physician's divulgence in terms of what he knows or should know to be the patient's informational needs. If, but only if, ... (it) was unreasonably inadequate is an imposition of liability legally or morally justified.

464 F.2d at 787.

Despite its emphasis on patient autonomy and the right to make a free choice, the law of informed consent, as expressed in both statute and case law, recognizes certain exceptions. In emergencies, a physician need not make full disclosure.[3/] Nor need he do so when a patient expresses a desire not to hear certain information.[4/]

3/ See generally, Informed Consent, supra note 2 at 14-19 and cases cited therein. See also, Ohio Rev. Code Ann. § 2317.54 (1981), supra note 1; Canterbury v. Spence, 464 F.2d 772, 789 (D.C. Cir. 1972) and sources cited therein.

4/ See. e.g., 18 Del. Code Ann. § 6852 (Cum. Supp. 1980) (In a defense to a civil suit for damages a physician may assert that "the injured party assured the health care provider he or she would undergo the treatment regardless of the risk involved or that he or she did not want to be given the information or any part thereof to which he or she could otherwise be entitled.") Similar provisions are included, inter alia, in N.H. Rev. Stats. Ann. § 507-C:2 (Supp. 1979); N.Y. Public Health Law, 44 McKinney § 2805-d (McKinney 1977); Utah Code Ann. § 78-145 (1977).

Finally, a "therapeutic privilege" is widely recognized[5/] whereby a physician may withhold certain information

> when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view. It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, complicate or hinder the treatment, or perhaps even pose psychological damage to the patient.

464 F.2d at 789.

5/ See e.g., 18 Del. Code Ann. § 6852 (Cum.Supp. 1980) (Allows physicians to assert as a defense to an action for damages for failure to obtain informed consent that "it was reasonable for the health care provider to limit the extent of his or her disclosures of the risks of the treatment, procedures or surgery to the injured party because further disclosure could be expected to affect, adversely and substantially, the injured party's condition, or the outcome of the treatment, procedure or surgery." Thomas v. Berrios, 348 So. 2d 905 (Fla. Ct. App. 1977); N.H. Rev. Stat. Ann. § 507-C:2 (Supp.1979). See generally, Informed Consent, supra note 2 at 54-56 and 75-185. (State-by-state analysis of statutory and case law on informed consent.)

The Akron Ordinance conflicts with the traditional legal doctrine of informed consent primarily in its inflexibility. It does not allow the physician to tailor the information to the needs of the individual patient. Nor does it give the physician the discretion to adjudge the materiality of a particular fact to a particular patient's situation, to withhold even relevant information that would be harmful to a patient or to accede to a patient's wish not to hear the information.

There are many situations in which a physician might conclude that listening to a detailed description of fetal anatomy is not relevant to every patient's abortion decision or should be withheld because it would cause a particular patient undue anxiety, even physical pain. Many patients may simply not want to hear this information prior to receiving an abortion. As the First Circuit stated in striking down a requirement that women read a description of the fetus prior to obtaining an abortion,

> (f)irst, the information is not directly material to any medically relevant fact, and thus does not serve the concern for providing adequate medical information that lies at the heart of the informed consent requirement. Second, the uncontradicted expert testimony at the hearing below indicated that requiring women seeking abortions to read this information would cause many of them emotional distress, anxiety, guilt and in some cases increased physical pain... In addition, these effects might well be thought likely to be even greater for certain classes of women for whom the abortion decision is intrinsically more stressful, including those who had been rape victims, who were very young, or who sought an abortion because of danger to their own health or indications that the fetus...might be born deformed... Finally, ...the uncontradicted testimony indicated both that most women would not want to hear such a description just prior to having an abortion and that most physicians would not consider it good medical practice to provide one...

641 F.2d at 1021-22. See also, Charles v. Carey, 627 F.2d 772, 784 (7th Cir. 1980). ("The prospect of such 'required reading' for the woman who elects to abort a fetus because of serious genetic defects or because her own health is in danger is punitive to the woman and compromising to the physician's efforts to do what is best for her.")

Section 1870.06 (B)(5)'s list of risks which must be disclosed in all cases contains statements which the majority of physicians would adjudge immaterial to a woman's abortion decision because they are false, still scientifically unproven or extremely remote.

The section directs the physician to tell a woman that abortion is major surgery. This statement is simply not true, at least for the 91% of abortions performed in the first trimester of pregnancy.[6/] Early abortion is in fact one of the safest surgical procedures.

The mortality rate for legally induced abortion in the first trimester is 1.5 deaths per 100,000 procedures.[7/] By comparison, a routine tonsillectomy is twice as risky and an appendectomy 100 times more dangerous.[8/]

6/ U.S. Department of Health and Human Services, Centers for Disease Control, Abortion Surveillance: 1978 4 (1980).

7/ Cates & Grimes, Morbidity and Mortality of Abortion in the United States, Table 4 in Abortion and Sterilization: Medical and Social Aspects (Hodgson ed. 1981) (hereinafter "Morbidity and Mortality").

8/ Id. at 168-69. A "major operation" is defined as "An extensive, relatively difficult surgical procedure, frequently involving a major cavity of the body, or
(footnote continued on next page)

The risk of abortion at this stage is similar to that of a penicillin injection.[9] Accord, Margaret S. v. Edwards, 488 F.Supp. 181, 210 (E.D. La. 1980); Akron Center for Reproductive Health v. City of Akron, 479 F.Supp. 1172, 1207 (N.D. Ohio 1979), aff'd, 651 F.2d 1198 (6th Cir. 1981).

The Ordinance further requires the physician to tell the woman that abortion may result in "serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies." Even early suction curettage abortion does carry some risk of uterine perforation (0.1 to 0.2 perforations per 100 procedures)[10] infection (0.1 to 2.2 per 100 procedures)[11] and hemorrhage (0.05 to 4.9 pe

(footnote continued from previous page)
requiring general anesthesia; one which demands of the surgeon a special degree of experience or skill." Gould Medical Dictionary (4th ed. 1979). First trimester suction curettage abortion can hardly be said to fit this definition.

9/ Cates et al., Abortion as a treatment for unwanted pregnancy: the number two sexually-transmitted condition, 12 Advances in Planned Parenthood 115, 120 (1978).

10/ Morbidity and Mortality, supra note 7 at 163.

11/ Id. at 162.

100 procedures).[12] These complications are rarely "serious," however. For example, only about one in seven cases of hemorrhage requires blood transfusion to replace lost blood.[13] Infection usually responds to treatment with antibiotics, but hospitalization is sometimes necessary. Moreover, sterility is seldom a direct result of abortion but usually results from rare but extemely serious complications that may occur. For example, infection can, in very rare cases, become so extensive that hysterectomy is necessary. Without the foregoing caveat, however, it is misleading to say that "abortion...can result...in sterility."

The most recent studies indicate that there is no evidence linking one previous induced

12/ Id. Reported rates of hemorrhage vary so widely because of "lack of uniformity in definition of hemorrhage and imprecision in identifying blood loss." Id.

13/ Id.

abortion to later spontaneous abortion (miscarriage).[14/] The studies are in conflict on the relationship between repeat abortions and the outcome of a future pregnancy. Some studies have found a correlation; others have not.[15/] One recent Hawaii study examined the records of 16,691 women who obtained legal abortions in the state between 1970 and 1974. It found that the frequency of miscarriage was more related to the length of time a woman waited before becoming pregnant again after having had an abortion than to the number of abortions she had had. Women whose previous pregnancies had resulted in either abortion or live birth were more likely to miscarry if they conceived again within a year than if they waited

14/ No Increased Risk of Spontaneous Abortion Among Women With a Previous Induced Abortion, 13 Family Planning Perspectives 238 (1981).

15/ Id.

longer to become pregnant again.[16]

The evidence on whether induced abortion can cause future premature births is likewise inconclusive. A multinational study conducted by the World Health Organization found no correlation between delivering a premature or low-birth weight infant and a previous induced abortion by the vacuum aspiration method, the most widely used method in the United States.[17] If dilatation and sharp curettage was used, however, there was some indication of a slightly increased risk of prematurity, although another research project found no correlation, even with this method.[18] There is somewhat clearer indication that when abortion is complicated by infection or there are multiple abortions, the risk of prematurity may be increased, but the results are still inconclusive.[19]

16/ Id. at 239.

17/ D. Main, Does Abortion Affect Later Pregnancies? 11 Family Planning Perspectives 98, 99 (1979).

18/ Id. at 100.

19/ Id.

The Akron Ordinance's requirement that a woman be told that abortion "may leave essentially unaffected or may worsen any existing psychological problem and can result in severe emotional disturbances" likewise distorts the severity of abortion sequelae. Studies conducted on women receiving legal abortion show that post-abortion psychosis is extremely uncommon and has a considerably lower incidence than such disturbances following childbirth (puerperal psychosis).20/ One study of abortion patients showed that, although nearly all women approach abortion with some degree of ambivalence and emotional distress, nearly half of women report resolving their problems within four months of the procedure. The predominant feeling among the group surveyed was relief that the pregnancy had been terminated. Only 24% of those who had wanted the pregnancy and 11%

20/ Brewer, C. Incidence of Post-Abortion Psychosis: a Prospective Study, 1 British Medical Journal 476 (1977).

of those who had not wanted it experienced depression four months later. Continued disturbance about the abortion resulted most prominently from lack of support in the decision from the male partner.[21/]

Another way in which the Akron Ordinance forces the physician to act against his patient's best interests is by not allowing an exception to the disclosure requirement in emergency situations. This is an exception universally recognized in tort law.[22/] Its omission can hardly be viewed as inadvertent, since section 1870.12 specifically allows the physician to dispense with the "Informed Consent" section's requirement for a parent's co-signature on a consent form in emergencies, yet fails to allow the physician to dispense with the required recitations. Thus, even when a woman's life is in danger a physician must recite the

21/ Freeman, E. Abortion: Subjective Attitudes and Feelings, 10 Family Planning Perspectives 150, 153, 154. (1978).

22/ Note 3, supra.

required script. A physician faced with an unconscious patient obviously acts at his or her peril vis a vis the criminal law in performing even a life-preserving abortion.

The foregoing demonstrates that the Akron Ordinance conflicts with the accepted medical/ legal meaning of informed consent by requiring the physician to make statements which he or she may rationally conclude to be medically irrelevant, false and/or harmful to a patient. The statute presents a conflict with a physician's professional duty and judgment on an even more elementary level. It is axiomatic that the law cannot require a physician to give information which is simply outside the realm of medical competence. This is typified by the Act's requirement that the doctor tell the woman that "her unborn child is a human life from the moment of conception." The beginning of human life is a personal, philosophic or religious value judgment, not a medical or scientific fact. Roe v. Wade, 410 U.S. 113, 159-61 (1973).

Requiring a physician to make statements which are outside the realm of his medical competence and which may be directly contrary to his or the woman's deeply held personal beliefs is perhaps the most offensive "straitjacket" of all.23/

In summary, the Akron Ordinance poses a direct and significant interference with a woman's abortion choice by burdening her physician with criminal penalties for failure to make statements in conflict with his or her professional judgment.24/

23/ See discussion at section I.B. infra on first amendment implications.

24/ The burdens on the physician are heightened by the statute's vagueness. For example, the physician must, upon request, provide the woman with a "list of agencies" to help her carry her pregnancy to term, yet there is no indication of what such a list must comprise in order to be legally adequate. The required disclosure of fetal anatomy is "including but not limited to" a list of fetal attributes. Yet a physician cannot know when he has completed a legally adequate description. The importance of statutory vagueness in chilling the physician's willingness to perform abortions and, hence, a woman's ability to receive them was recognized in Colautti v. Franklin, 439 U.S. 377, 390-97 (1979).

The search for any legitimate state interest to justify this intrusion is pointless. "There is no rational reason, much less a compelling state interest, that justifies forcing physicians to give women information that physicians consider injurious to the woman's health or simply untrue." Planned Parenthood of Kansas City v. Ashcroft, 655 F.2d 848, 868 (8th Cir. 1981). The Constitution cannot tolerate such draconian means of pursuing the otherwise admirable aim of assuring a woman's free and informed choice.

B. Section 1870.06 (B) Abridges First Amendment Rights of Physicians and Patients.

I. Section 1870.06 (B) violates physicians' first amendment right to be free from state compelled speech.

As demonstrated in the foregoing discussion, section 1870.06 (B) requires physicians to affirm beliefs they may not hold, to convey to patients medical opinions with which they may disagree, and to utter statements as proven facts which they may believe to be empirically false or hypothetical. By so doing, the Ordinance also violates a central guarantee of the first

amendment: that an individual has a right to be free from government coerced speech in matters of belief, opinion and ideology.

> A system which secures the right to proselytize religious, political, and ideological causes must also guarantee the concomitant right to decline to foster such concepts. The right to speak and the right to refrain from speaking are complementary components of the broader concept of "individual freedom of mind"...where the state's interest is to disseminate a ideology, no matter how acceptable to some, such interest cannot outweigh an individual's First Amendment right to avoid becoming the courier of such a message.

Wooley v. Maynard, 430 U.S. 705, 714, 717 (1977).

Accordingly, this Court has invalidated state action compelling individuals to utter by word or sign beliefs that they did not hold. For example, in West Virginia State Board of Education v. Barnette, 319 U.S. 624 (1943), this Court held that the flag salute and pledge of allegiance could not be compelled, for to do so would be to "prescribe what shall be orthodox in politics, religion or other matters of opinion." Id. at 642. And in

Wooley v. Maynard, the Court struck down New Hampshire's law against covering the motto "live free or die" on license plates on the ground that it forced individuals to foster an idea they found morally objectionable. 430 U.S. at 715. See also, Elrod v. Burns, 427 U.S. 347 (1976)

The Akron Ordinance falls squarely within the type of state coerced speech this court has held unconstitutional. The best example of this is the requirement that the physicians tell the woman that her "unborn child is a human life from the moment of conception." This Court has explicitly held that the concept of "when life begins" is a matter of religious and philosophical belief. Roe v. Wade, 410 U.S. 113, 160 (1973). The Ordinance thus forces physicians to be couriers of an ideological message in identical manner to the plaintiffs in Maynard who had to bear the motto

"live free or die" on their license plates.[25]

In like manner, the Ordinance requires physicians to tell their patients an abortion is major surgery, a matter of opinion with which most physicians disagree, and to state as true abortion risks which many physicians will believe to be hypothetical, if not inaccurate.[26]

25/ In so far as views on the beginning of human life are part of religious value systems, requiring physicians to make a statement affirming that human life begins at conception may interfere with the free exercise component of the first amendment, as well as free speech. In McRae v. Califano, 491 F.Supp. 630 (E.D. N.Y. 1980), reversed sub nom Harris v. McRae, 448 U.S. 297 (1980) the Court found that in the Jewish legal view, "no person is in existence until the infant emerges from the womb into the world," Id. at 697, and the "mainstream Protestant view" is that "human personhood -- in the sense in which the person receives its maximum value in relation to the Christian faith ... does not exist in the earlier phases of pregnancy," Id. at 742. See Torcaso v. Watkins, 367 U.S. 488 (1961) (free exercise clause violated by requiring affirmation of belief in God as a condition of holding public office). Although this Court has held that beliefs in the propriety or impropriety of abortion are not so uniquely religious that anti-abortion legislation amounts to an establishment of religion, it has yet to deal with the question raised here, that requiring affirmation of the value and beginning of human life violates free exercise rights. See Harris v. McRae,448 U.S. 297, 319-320 (1980).

26/ See text surrounding notes 6 through 21 supra.

If the first amendment limits a state's authority to compel affirmation of ideologies and beliefs with which the individual disagrees, it must certainly protect an individual from being compelled to utter statements which are simply untrue.

The requirement that the physician describe the fetus to the woman also attempts to use the physician as the mouthpiece for the state's anti-abortion viewpoint. Although the information to be given is factual in nature, the real purpose of the requirement is not to inform but to dissuade women from having abortions. This is especially true in light of the fact that many patients will not consider this information relevant to their decision or even wish to hear it, and with regard to these patients, the physicia is forced into a role inconsistent with a good doctor-patient relationship. The First Circuit applied a similar first amendment analysis in striking down a Massachusetts fetal description requirement. The court first recognized that "the primary purpose of the required information is not so much factual as it is moral," and th

explained:

> To the extent that information may be imposed by the state it must be neutral and objective; coercive state indoctrination of particular values or ethical judgments is objectionable to First as well as Fourteenth Amendment principles. The state may not add to its presentation of material facts such a moral overlay, an attempted imposition of ideas that is particularly objectionable in connection with the exercise of fundamental rights.

Planned Parenthood League of Massachusetts v. Bellotti, 641 F.2d 1006, 1022 (1st Cir. 1981).

For the foregoing reasons, section 1870.06 (B) should be held to violate physicians' first amendment right to be free from state compelled speech.

2. Section 1870.06 (B) abridges patients' first amendment right to refuse to listen to the state's ideological messages.

Section 1870.06 (B) contains information which may be viewed as ideological in nature and may be offensive to individuals' deeply held religious and philosophical beliefs. By requiring all women to listen to this information as an absolute precondition of obtaining a legal abortion, the Ordinance violates the first amendment rights of captive auditors not to be accosted by the state's ideological messages.

Just as the right to speak freely necessarily encompasses a right to refrain from speaking at all, Wooley v Maynard, 430 U.S. 705, 714 (1977), so too the now established first amendment right to receive information and ideas, Stanley v. Georgia, 394 U.S. 557, 564 (1969), necessarily implies a right to refuse them:

> ...the Constitution protects more than just a man's freedom to say or write or publish what he wants. It secures as well the liberty of each man to decide for himself what he will read and to what he will listen. The Constitution guarantees, in short, a society of free choice.

Ginsberg v. N.Y., 390 U.S. 629, 649 (1968) (Stewart, J., concurring). On a number of occasions, this Court or the individual Justices have alluded to this right as circumscribing the state's power to impose political or otherwise offensive messages on captive audiences, most notably passengers on state-owned transit vehicles. See e.g., Public Utilities Commission v. Pollak, 343 U.S. 451 (1952)

(because radio programs broadcast on public buses did not contain "objectionable propaganda" they did not violate passengers' right to refuse to listen.) See also, Id. at 466 (Black, J., concurring); Id. at 467 (Douglas, J., dissenting); Lehman v. Shaker Heights, 418 U.S. 298, 307 (1974) (Douglas, J., concurring).

A woman sitting in a doctor's office or an abortion clinic, forced to listen to a state mandated anti-abortion lecture, is perhaps more "captive" than any of the auditors previously considered by the Court. Like the streetcar passenger, she "has no choice but to sit and listen, or perhaps sit and try not to listen." Public Utilities Commission v. Pollak, 343 U.S. at 469 (Douglas, J., dissenting). Yet, unlike the streetcar passenger who can avoid an offensive message by simply getting off the car, she has no realistic alternative available.

Legal abortion is the only safe means of terminating a pregnancy. To force a woman to choose between a legal abortion and avoiding an offensive state lecture is to violate both first and fourteenth amendment rights.27/

27/ In so far as a woman is forced to listen to information that is in conflict with her religious beliefs, the Ordinance violates the woman's right to free exercise of religion as well. See note 25 supra. See also, Abington School District v. Schempp, 374 U.S. 203, 288-89 (1963) (Brennan, J., concurring) (free exercise right to be excused from Bible reading in public schools).

II. SECTION 1870.06(C) OF THE AKRON ORDINANCE, REQUIRING INFORMED CONSENT COUNSELING BY THE ATTENDING PHYSICIAN, SIGNIFICANTLY INTERFERES WITH A WOMAN'S RIGHT TO ABORTION AND IS NOT JUSTIFIED BY ANY STATE INTEREST

Section 1870.06 (C) of the Akron Ordinance requires that the same physician who performs the abortion must personally provide his or her patient with the statutorily required "informed consent" information. This requirement prohibits the attending physician from delegating to another physician or to trained counselors the task of providing this information even when the doctor's best medical judgment dictates such delegation. Amici believe that the determination as to which health professional is best equipped to provide the informed consent information is best left to the professional judgment of the woman's attending physician. By dictating who should provide this information, the Akron Ordinance places unjustifiable "obstacles in the path of the doctor upon whom (the woman)

is entitled to rely for advice in connection with her decision". Whalen v. Roe, 429 U.S. 589, 604 n.33 (1977). It is precisely the sort of "strait-jacketing" of medical practice this Court warned of in connection with laws dictating the content of the informed consent dialogue. Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52, 67 n.8.[28/] The court of appeals was correct in recognizing this and in holding the requirement unconstitutional. 651 F.2d at 1207. Accord, Charles v. Carey, 627 F.2d 772, 784 (7th Cir. 1980), Planned Parenthood of R.I. v. Roberts, 530 F.Supp. 1136, 1147 (D.R.I. 1982).

The attending physician counseling requirement directly burdens the woman's access to abortion in a number of ways. First, it makes abortions more expensive and less available. Second, it impedes good medical practice.

By requiring physicians, the most highly paid

28/ See page 10 supra and cases cited therein.

members of the health care delivery team,[29] to spend time imparting to patients information that can be communicated equally well, if not better, by a trained counselor, the Ordinance will inevitably raise the cost of abortions. Moreover, because of the shortage of trained physicians, the increased time demanded may result in decreased availability of abortions.[30] The federal district court in Rhode Island summarized this effect well:

> A primary component of the cost of an abortion is the cost of the doctor's time. One way to cut some of the costs of surgery is to restrict the use of doctor-time to those services that only the doctor can provide. In this way, a hospital or other medical facility can make the highest and best use of doctor's time and, concomitantly, reduce the cost of the peripheral services that make up the total package. For example,

29/ Amicus Planned Parenthood Federation of America's (PPFA's) affiliates who provide abortion services report that physician salaries are six or seven times that of the counselors who currently provide the informed consent information. See note 32, infra.

30/ Increased cost and decreased availability resulting from direct state regulation in the area of reproductive privacy have long been held by this Court to give rise to strict judicial scrutiny. Carey v. Population Services Int'l, 431 U.S. 678, 689 (1977); Doe v. Bolton, 410 U.S. 179, 193-95 (1973).

> (plaintiff) clinics keep the costs of abortions down by attempting to utilize doctor-time only for the actual surgery. The counselling and informing functions are performed by other professionals whose time is not as expensive as a doctor's. By not "under-employing" doctors, these clinics provide an abortion at its optimal cost. The clinics' practice helps alleviate the shortage discussed above. By utilizing a doctor's time in the most efficient fashion, the clinics free their doctors to do more of the things that only they are capable of doing. The State's "same physician" requirement will disrupt this method of proceeding, thereby increasing the cost of abortions and aggravating the increasing doctor shortage.

Planned Parenthood of Rhode Island v. Roberts, 530 F.Supp. at 1148. The plaintiffs' witnesses testified in the district court that the requirement, especially when coupled with the required waiting period, was "likely to lead to the shutdown of the clinics or a substantial increase in their operating cost."[31/] Affiliates of amicus Planned Parenthood Federation of America (PPFA), when questioned about the effect of a physician counseling requirement on their operations, answered almost unanimously that substantial, if not prohibitive, increased

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31/ Joint Appendix filed in the Court of Appeals (J.A.) 116, 222-224, 458, 521 as cited in Respondents' Consolidated Brief in Opposition to Certiorari at 20.

costs would result.[32/]

In addition to the financial and access burdens, the physician counseling requirement interferes with good medical practice. As the federal district court in Rhode Island noted,

> (m)uch of the testimony at trial indicates that the national trend is toward the use of trained and supervised "paraprofessionals" to deliver the information and counselling that leads to informed consent for any surgical procedure. This trend has developed in response to a national desire to lower the cost of medical care and to offset a national shortage of doctors, and in recognition of the fact that doctors often are not the best people to perform this function. Several doctors who testified in this case indicated that they felt that a trained counsellor could be much more effective in obtaining truly informed consent than could the attending physician. This is particularly true in the area of abortions where counselling skills may be as important to the success of the procedures as is surgical technique. Counsellors may also be better at searching out ambivalence or anxiety than would a physician.

530 F.Supp. at 1148 (emphasis added).

This "national trend" toward use of trained

32/ PPFA's thirty-nine affiliates which provide abortion services were surveyed informally regarding the effect that a law similar to Akron's would have on clinic operations. Twenty-eight responses were received. The information presented in this section and section III regarding affiliate clinic practice is based on that survey. PPFA affiliate abortion providers performed 80,000 abortions in 1981.

paraprofessionals, id., is well exemplified at abortion clinics run by affiliates of amicus PPFA. A survey of these providers[33/] showed that virtually all use non-physician counselors to provide the informed consent information in the first instance, with physicians available to answer any questions the woman may have. The clinics report that this practice cuts costs but also serves the overall health interests of the patients.

Counselors typically are academically trained with undergraduate or graduate degrees in sociology, psychology, counseling or social work or are nurses or nurse practitioners. They are selected for and trained in listening and communication skills. Their most important qualification is the ability to "respect, understand and empathize with the woman as an individual. A counselor must have a sincere belief in the right of the woman to make her own decision after she has explored all the options."[34/]

33/ See note 32 supra.

34/ Planned Parenthood Federation of America, Manual of Medical Standards and Guidelines, Section VII-C p.22 (December 15, 1977) (hereinafter "PPFA Manual")

Counselors also must have knowledge regarding the medical aspects of the abortion procedure, its risks, its benefits and all alternatives including carrying the pregnancy to term and keeping the child or placing it for adoption.[35/]

PPFA's affiliates believe that counselors have superior skills in listening to the woman and surfacing her concerns regarding her pregnancy. They believe counselors can impart the medical information to the woman on a level she can understand and that women will feel more comfortable asking questions seeking medical information of counselors than of physicians, who may be regarded as authority figures by their patients. PPFA's Memphis affiliate has experienced complying with a similar Tennessee law during 1979, 1980 and 1981. In order to secure a truly informed consent from patients the affiliate found it necessary to continue utilizing its non-physician counselors to supplement the physician counseling. The affiliate wrote in reply to PPFA's survey,

35/ Id.

> For many women in our patient population, the "physician mystique" still exists and they are more comfortable and relate more easily to the counselor...(the patients) were extremely reluctant to ask questions of the physician. A counselor's specific training and skills which have developed in active listening, non-verbal communication, and being non-judgmental, enable her to become more capable of imparting to the woman on her level the informed consent information.[36]

Delegation of counseling duties to trained paraprofessionals is not an abrogation of responsibility on the part of the physician. Physicians at PPFA affiliate abortion providers typically prepare or approve the medical fact sheets that form the basis for the informed consent counseling sessions and are required, by PPFA standards, to be available to answer the woman's questions.[37] The best insuror, however, of physician responsibility and the patient's receipt of informed consent is the present common law of medical malpractice,

36/ Reply of Memphis Association for Planned Parenthood to survey, note 32 supra. Survey answers are on file at PPFA offices, New York New York.

37/ PPFA Manual, supra note 34 at

which holds a physician liable in damages for failure to secure informed consent.[38] That law does not require that the patient receive the information from any particular source, but does hold the physician responsible if the information is not imparted.[39]

For all the foregoing reasons, good medical practice holds that a trained counselor can do a superior job in securing informed consent from an abortion patient, in addition to cutting costs substantially. Prohibiting physicians from delegating the duty of informing the patient to a counselor [40] thus significantly interferes with a woman's right to abortion. While Akron has advanced an interest in protecting the woman's health

38/ See discussion at pages 12-15 supra.

39/ A. Rosoff, Informed Consent: A Guide for Health Care Providers 45 (1981). See e.g., Stills v. Gratton, 55 Cal.App.3d 6298 (1976). In this regard, Respondents' contention that the Ordinance's requirement that the physician personally inform the patient merely reiterates "his common law and ethical duty" is incorrect. Brief for Petitioner City of Akron at 40.

40/ Significant burdens are also imposed by prohibiting the physician from delegating either the counseling or

(footnote continued on next page)

as a justification for the requirement, there is no indication of how this interest is served by a statute that forces physicians to act in a manner which is against good medical practice. For these reasons, the court of appeals' judgment that section 1870.06 (C) is unconstitutional should be affirmed.

(footnote continued from previous page)

the performance of the abortion to a physician colleague. See Charles v. Carey, 627 F.2d 772, 784, (7th Cir. 1980), Planned Parenthood of Rhode Island v. Roberts, 530 F.Supp. 1136, 147 (D. R.I. 1982).

III. SECTION 1870.07 OF THE AKRON ORDINANCE, THE TWENTY-FOUR HOUR WAITING PERIOD, WOULD HAVE A SIGNIFICANTLY HARMFUL IMPACT ON A WOMAN'S RIGHT TO ABORTION AND DOES NOT SERVE ANY STATE INTEREST

The court below correctly held that the Akron Ordinance's requirement that a woman wait twenty-four hours between the time her physician personally gives her informed consent information and she receives an abortion has a significant impact on a woman's constitutionally protected right to choose abortion, and, therefore, warrants strict judicial scrutiny. Akron Center for Reproductive Health v. City of Akron, 641 F.2d 1198, 1208 (6th Cir. 1981). Far from serving a compelling state interest, which would be necessary to support such a restriction, there is no state interest whatsoever that justifies the mandatory waiting period. Id. Amici, therefore, urge the affirmance of the court of appeals' decision, which is consistent with three

circuits,[38] that a state-mandated waiting period is unconstitutional.

Mandatory waiting periods will inevitably entail delays beyond the statutorily prescribed time. This is caused by a number of factors. First, abortion procedures are not performed every day in most clinics. For example, the Akron clinics perform abortion procedures only three days a week and procedures requiring general anesthesia only once a week.[39] Second, the requirement that

38/ Planned Parenthood of Kansas City v. Ashcroft, 655 F.2d 848, 866 (8th Cir. 1981); Planned Parenthood League of Massachusetts v. Bellotti, 641 F.2d 1006 (1st Cir. 1980); Charles v. Carey, 627 F.2d 772 (7th Cir. 1980). Accord, Women's Services P.C. v. Thone, 636 F.2d 206, 210 (8th Cir. 1980); Planned Parenthood of Rhode Island v. Roberts, 530 F.Supp. 1136 (D.R.I. 1982); Leigh v. Olson, 497 F.Supp. 1340, 1347 (D.N.D. 1980); Margaret S. v. Edwards, 488 F.Supp. 181, 212 (E.D. La. 1980); Women's Health Center v. Cohen, 477 F.Supp. 542, 550 (D. Me. 1979).

39/ Respondents' Consolidated Brief in Opposition to Certiorari at 22.

the attending physician be the one to administer the informed consent information greatly compounds the actual delays involved. While physicians are present every day that abortion procedures are performed, the same physician is not necessarily present each day. A typical pattern at the clinics run by amicus Planned Parenthood Federation of America's (PPFA's) affiliates is for physicians to rotate on a weekly basis.[40] A patient who receives the consent information from her physician would, therefore, have to wait until the following week when he or she returned to duty to have her abortion. The problem would be further complicated by vacation schedules or illness of the attending

40/ Amicus PPFA surveyed its affiliate abortion providers to determine how the Akron Ordinance's attending physician counseling requirement (§ 1870.06(C)) and waiting period (§ 1870.07) would affect clinic practice. Twenty-eight of thirty-nine providers responded to the survey. The information presented here regarding PPFA affiliate clinic practice is based on that survey.

physician [41] and the woman's own school or job schedule

Delaying an abortion even one week is medically unacceptable because the risks to the woman increase dramatically with each week of pregnancy. A woman who cannot obtain an abortion until the tenth week of pregnancy faces a 57% greater risk of suffering from a major complication than she does in the eighth week. The risk of major complications is 91% greater in the eleven to twelve week interval than in the eighth week.[42] The risk of death from abortion increases by 50% with each week of delay.[43]

Another variable that affects abortion morbidity and mortality is the method used to

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41/ One affiliate reports utilizing seventeen physicians who are on duty once a week over a seventeen week span. See note 40 supra.

42/ Cates, et al., The Effect of Delay and Method Choice on The Risk of Abortion Morbidity, 9 Family Planning Perspectives 266 (1977).

43/ Cates & Tietze, Standardized Mortality Rates Associated with Legal Abortion: United States, 1972-1975, 10 Family Planning Perspectives 109, 111 (1978).

perform the procedure, which changes with gestational age. Vaginal suction curettage or dilatation and evacuation (D & E) procedures performed at earlier stages of gestation are safer than instillation procedures done later.[44/] Indeed, there is evidence that a decline in the number of deaths relating to abortions can be traced partly to performing abortions earlier and using the safer procedures.[45/] A delay that forces a physician to use a less safe abortion procedure is, obviously, contrary to good medical practice and to the interests of preserving health.

Additionally, second trimester procedures are often not as readily available as are abortions performed during the first trimester. Many jurisdictions, including Akron, Ohio, require that

44/ Cates, et al., supra note 42 at 268.

45/ U.S. Dept. of Health and Human Services, Centers for Disease Control, Abortion Surveillance: 1978 9 (1980).

second trimester procedures be performed in a hospital, thus substantially increasing the cost to the woman.[46/] If the state-mandated waiting period delays the abortion into the second trimester, therefore, an abortion may become extremely difficult or impossible to obtain for many women.

Delay can also result in heightened emotional distress for the pregnant woman. In a recent study on attitudes of women receiving abortions towards a mandatory waiting period in Tennessee, 60% of the women surveyed agreed with the statement that "having to wait for the abortion has caused me a lot of added stress and worry

46/ Only one in ten non-Catholic general hospitals offer any second trimester abortions. Henshaw et al., Abortion Services in the United States, 1979 and 1980, 14 Family Planning Perspectives 5, Table 12 (1982). Nationally, in 1978, second trimester dilatation and evacuation (D & E) abortions were two to three times as expensive in hospitals as similar procedures in clinics. Rosoff, The Availability of Second Trimester Abortion Services in the United States 35 in Second Trimester Abortion: Perspectives After a Decade of Experience (Berger, Brenner and Keith eds. 1981).

about my condition." 47/

In addition to the adverse effects on the woman's health, the mandatory waiting period can impose substantial financial burdens. The cost of travel and lost wages is compounded when a woman must return on another day for the abortion procedure. Babysitting costs and the expense of overnight accommodations when the clinic is located far from the woman's home must be added to the financial impact.48/ Extensive travel to reach abortion providers is the rule rather than the

47/ Lupfer & Silber, How Patients View Mandatory Waiting Periods for Abortion, 13 Family Planning Perspectives 75, Table 1 (1981)

48/ In the survey of Tennessee abortion patients, where the women typically lived 80 miles from the urban center where the clinic was located, 59% reported having to bear additional travel expenses. Forty-one percent of those surveyed reported losing wages because of the waiting period; the median loss was $32. Forty-five percent of the women were mothers with young children; 22% of these had to pay for additional child care because of the waiting period. Id. at 77.

exception in the United States, especially for rural women. Almost 70% of women living in non-metropolitan areas live in counties with no facility reporting even one abortion and 95% live in counties without a provider reporting 400 or more abortions a year.[49/] Perhaps the most serious financial burden will be the added cost, which the clinics will have to pass on to the patients, arising from the need to schedule the woman for two visits with a physician.[50/]

Amici strongly support the practice of affording a woman sufficient time to make a thoughtful and knowledgeable decision regarding the abortion. In fact, PPFA abortion providers typically schedule pregnancy testing and counseling on a different day from surgery.[51/]

49/ Henshaw et al., supra note 46 at 10.

50/ See text surrounding notes 29 through 32 supra.

51/ See note 40 supra.

However, two crucial factors distinguish this common provider practice from the mandatory scheme imposed by the Akron Ordinance. First, at Planned Parenthood abortion clinics the informed consent counseling is typically performed by a trained non-physician counselor. Thus, the difficulties in attempting to schedule two visits with the physician who performs the abortion are avoided and actual delay and financial impact are minimized; abortions can, in reality, occur twenty-four hours after counseling. Second, and perhaps most crucial, such practice is not inflexible. PPFA affiliate abortion providers which serve rural populations will typically provide a "same day" service to accommodate woman who must travel far to receive their abortions.[54/] Thus, the fault in grafting

54/ For example, at one affiliate which provides such a service, 55% of the clients travel fifty miles or more to the clinic which is the only first trimester outpatient abortion facility in eight counties.

what may be generally good medical practice onto the criminal law is the straitjacket it applies to physicians' ability to tailor practice to the needs of the individual patient. See, Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52, 76. n.8. (1976).

Amici have shown that the waiting period is not only a direct obstacle to the woman's decision to obtain an abortion, but will also result in substantial medical, emotional and financial harm for many women. Such a restriction must be held invalid, therefore, as to the first trimester of pregnancy, when no state interests can justify such intrusion. 651 F.2d at 1208. Moreover, the harm inflicted upon women by this provision directly conflicts with the sole compelling state interest which this Court has identified as arising at the end of the first trimester of pregnancy and prior to fetal viability -- the health of t woman. Roe v. Wade, 410 U.S. 113, 163 (1973). Even if a waiting period could be justified

in principle by the rationale offered by Akron and rejected by the Court of Appeals as "the insurance that a woman's abortion decision is made after careful consideration of all the facts applicable to her particular situation," 651 F.2d at 1208, the mandatory and inflexible requirement of the Ordinance is hardly narrowly tailored to serve that interest. 410 U.S. at 163. Courts have consistently found that women carefully consider their decision to terminate a pregnancy before their first visit to a clinic. Planned Parenthood League of Mass. v. Bellotti, 641 F.2d at 1015; Women's Community Health Center v. Cohen, 477 F.Supp. at 551; Planned Parenthood Ass'n of Kansas City, Mo. v. Ashcroft, 483 F.Supp. at 696, affirmed 655 F.2d 848 (8th Cir. 1981). The Tennessee study discovered that the vast majority (88%) of women discussed the decision to obtain an abortion with at least one other person before speaking to a counselor at a clinic. Most commonly the other person was the woman's partner or

a close friend.[53] In a second Tennessee survey, conducted at the close of the waiting period, the majority of the women (55%) disagreed with the statement that "the required waiting period has been beneficial because it has given me time to think to be sure I was doing the right thing."[54]

The waiting period imposed by the Ordinance is a mandatory, inflexible requirement that will result in delay beyond the 24-hour limit and will increase the health risks and financial burdens to the patient. As there is no state interest, compelling or otherwise, that justifies these burdens, *amici* ask that this Court hold the waiting period unconstitutional.

53/ Lupfer & Silber, *supra* note 47 at 76.

54/ *Id.* at Table 1. 82% of the women felt they had carefully thought about the morality of abortion before approaching the clinic and did not need the waiting period to consider it further. *Id.*

IV SECTION 1870.03 OF THE AKRON ORDINANCE, REQUIRING THAT ALL POST-FIRST TRIMESTER ABORTIONS BE PERFORMED IN HOSPITALS IS UNCONSTITUTIONAL BECAUSE IT IS NOT A REASONABLE MEANS OF PROTECTING MATERNAL HEALTH

Amici urge reversal of the court of appeals' ruling that section 1870.03 of the Akron Ordinance is constitutional. The court of appeals found "persuasive" the argument that requiring all post-first trimester abortions to be performed in hospitals was not a reasonable means of protecting maternal health, 651 F.2d at 1210, but declined to hold the Ordinance invalid because it felt bound by this Court's summary affirmance in Gary Northwest Indiana Women's Services v. Bowen, 496 F.Supp 894 (N.D. Ohio 1980), affirmed, _____U.S. _____, 101 S.Ct. 2012, 68 L.E .2d 321 (1981). Amici support Cross-Petitioners' position that the court below erred in according Gary-Northwest absolute precedential value and should have declared section 1870.03 unconstitutional based on the evidence before it.

PPFA and other of the amici have already filed a brief on the health

aspects of requiring that all post-first trimester abortions be performed in hospitals in another case pending before this Court, Planned Parenthood Association of Kansas City, Mo. v. Ashcroft, Nos. 81-1255 and 81-1623. Because of space limitations, amici refer the Court to the argument at pages 13 through 42 of that brief.

Amici's brief in the Ashcroft case demonstrated, inter alia, that a hospitalization requirement severely burdens women's access to second trimester abortions because few hospitals provide such services. Since filing the brief, amici have been able to obtain data on the national availability of dilatation and evacuation (D & E) abortions in hospitals. (It is this method of abortion which Cross-Petitioners argue can safely be performed in clinics).

The Alan Guttmacher Institute surveyed a random sampling of second-trimester hospital abortion providers in the United States and found that only eleven percent performed as many as one D & E procedure

per week.[55] Putting these figures into the context of the general unavailability of hospitalized second trimester abortion services, fewer than one percent (.79%) of general short term non-Catholic hospitals perform as many as one D & E procedure a week.[56] Requiring that all post-first trimester abortions be performed in hospitals, thus, seriously undercuts the availability of these services to pregnant women.

55/ D & E procedures were defined for the purposes of the survey as those performed past the fourteenth week since the first day of the woman's last menstrual period.

56/ Memorandum from Dr. Stanley Henshaw, Senior Research Associate, the Alan Guttmacher Institute (AGI), New York, NY to Dara Klassel, Staff Attorney, Planned Parenthood Federation of America (August 20, 1982). The memorandum is reproduced in Appendix A. The AGI annually collects data on abortion providers. AGI statistics have, since 1975, been accepted by the Census Bureau as the official statistics on abortion in the United States and are published each year in the U.S. Government Statistical Abstract.

V. SECTION 1870.05 (B) OF THE AKRON ORDINANCE, REQUIRING PARENTAL OR JUDICIAL CONSENT TO MINORS' ABORTIONS, PERMITS AN UNCONSTITUTIONAL VETO OF A MINOR'S ABORTION CHOICE

The court of appeals affirmed the district court's holding that § 1870.05 (B) of the Akron Ordinance delegates an impermissible veto to third parties to deny even a mature minor's abortion request. 651 F.2d at 1205, affirming 479 F.Supp at 1201.[57/] Amici support this holding and urge affirmance of the court of appeals.

Section § 1870.05 (B) of the Ordinance provides that no physician may perform an abortion on a minor under fifteen years old without

> (1) First having obtained the informed written consent of one of her parents or her legal guardian in accordance with Section 1870.06 of this Chapter, or
>
> (2) The minor pregnant woman first having obtained an order from a court having jurisdiction over her that the abortion be performed or induced.

This requirement directly contravenes this Court's holding in Bellotti v. Baird, 443 U.S. 622 (1979), that any judicial alternative to mandatory parental

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57/ Amici also fully support Cross-Petitioners' argument that no party had standing to appeal this issue to the court of appeals or to this Court and that Ohio law fails to provide a viable judicial alternativ to parental consent.

involvement in a minor's abortion decision must grant a minor the right to demonstrate to the court that she is mature enough to make the abortion decision independently and, if found to be mature, to have the court grant her request for an abortion. Id. at 643-44. This Court was quite explicit in holding that any statute that gives a presiding judge the discretion to overrule a mature minor's decision is invalid. Id. at 650. See also, id. at 652 (Stevens, J., concurring). The Akron Ordinance, containing no standards for judicial approval or disapproval of a minor's abortion request, utterly fails to guarantee this right of choice to the mature minor.

Amici strongly take issue with Respondent-Intervenors' argument that the state may properly treat all minors under fifteen as immature.[58/] This Court rejected any such approach in Bellotti.

> The nature of both the State's interest in fostering parental authority and the problem of determining "maturity" makes clear why the State generally may resort to objective, though inevitably

58/ Brief of Respondents Francois Seguin, M.D. and Patricia K. Black at 21.

> arbitrary, criteria such as age limits... for lifting some or all of the legal disabilities of minority. Not only is it difficult to define, let alone determine, maturity, but the fact that a minor may be very much an adult in some respects does not mean that his or her need and opportunity for growth under parental guidance and discipline have ended. As discussed in the text, however, the peculiar nature of the abortion decision requires the opportunity for case-by-case evaluations of the maturity of pregnant minors.

Id. at 643 n.23 (emphasis added). The "peculiar nature" of that decision includes the burdens of premature parenthood on young lives and the "grave and indelible" consequences of denying the minor the right to choose whether or not to carry a pregnancy to term. Id. at 642.

For all of these reasons, amici request that this Court affirm the court of appeals decision with regard to section 1870.05 (B).

CONCLUSION

For all the foregoing reasons, amici request that the Court of Appeals' judgment with respect to §§ 1870.05(B), 1870.06(B) and (C) and 1870.07 of the Akron Ordinance be affirmed and that the judgment with respect to §1870.03 be reversed.

Respectfully submitted,

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August, 1982

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MEMORANDUM

August 20, 1982

TO: Dara Klassel, Staff Attorney, PPFA
FROM: Stanley K. Henshaw, Ph.D., Senior Research Associate
RE: D & E abortion services in hospitals

s/ Stanley K. Henshaw

In July and August, 1982, The Alan Guttmacher Institute (AGI) surveyed 40 hospitals randomly selected from among those hospitals listed in the AGI survey of all U.S. abortion providers as having provided 10 or more second-trimester abortions in 1980. (The AGI data on the number of second-trimester procedures performed is based on the facilities' own definitions of "second-trimester." For some hospitals, however, state health department data on gestation were used; for these hospitals, abortions past 12 weeks LMP were regarded as second-trimester procedures.)

Of the 40 hospitals surveyed, two no longer perform second-trimester abortions and two refused to provide the necessary information. Of the remaining 36 hospitals, 19 percent (seven hospitals) reported that D & E procedures past 14 weeks LMP (weeks since the onset of the last menstrual period) are performed in their facilities. (At least six other hospitals provide abortions at 13-14 weeks but not past 14 weeks.) Of these, three hospitals perform fewer than one D & E procedure a week, leaving only 11 percent of the hospitals (four hospitals) performing as many as one D & E a week.

Therefore only about 11 percent of hospitals where 10 or more second-trimester abortions were performed in 1980 provide D & E abortions past 14 weeks LMP. Since 26.5 percent of all hospital abortion providers reported 10 or more second-trimester abortions in 1980, only 2.9 percent of hospital abortion providers perform as many as one D & E a week. Only a minority of all U.S. hospitals (27 percent) offer any abortion services, however; therefore less than one percent (0.79 percent) of all non-Catholic short-term general hospitals perform as many as one D & E a week.

APPENDIX A